MARCH 1954

Mental Hospitals

Volume 5 Number 3

in this issue:

Published by
AMERICAN PSYCHIATRIC ASSOCIATION

Architect's sketch of
South Carolina State Hospital's
four new buildings
for disturbed patients

Your Stake in

A.P.A. MENTAL HOSPITAL SERVICE

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The A.P.A. Mental Hospital Service was established to advance the treatment of the mentally ill through good administrative practices, by serving as a clearing house for technical information on all phases of mental hospital operation.

Starting in April, 1954, MENTAL HOSPITALS will be mailed directly to all major departments in the hospital. Until now, the magazine has been mailed in bulk to Superintendent for staff distribution. Although the new system calls for additional expense and labor, the Mental Hospital Service Consultants have recommended it to increase the value of the Service by bringing MENTAL HOSPITALS, its official publication, to the attention of more members of the hospital staff.

Incidentally: "Associate Service" subscriptions are being made available to mental health societies, related professional associations, architects and others who have major interests in the mental health field. Write for details.

MENTAL HOSPITALS

OFFICIAL PUBLICATION OF

AMERICAN PSYCHIATRIC ASSOCIATION MENTAL HOSPITAL SERVICE

THIS MONTH'S COVER

The four buildings for disturbed patients shown on this month's cover are under construction at the Columbia Division of the South Carolina State Hospital. The double-E shape of the buildings provides each with two interior exercise courts. These are paved with green concrete and have planting beds along the walls. Adjacent to each of the end wings is an additional exercise yard enclosed by climb-proof fences and having outside toilet facilities.

Two of the buildings are for men patients and two are for women. Each has a capacity of 152 patients in four nursing units of 38 beds. There are a number of single bedrooms provided on each nursing unit, as well as larger multiple-bed rooms to be operated on an open-ward basis; one building for each sex has wings containing about 20 private rooms for the more disturbed patients. Each of the nursing units contains large and small day rooms, nurses' stations, treatment rooms, a utility room, doctor's office, clothes and linen rooms and necessary toilet and bath facilities.

The nursing stations are strategically located to oversee the bedrooms, dayrooms and corridors. They are situated so that each has direct visibility of two others, in case of emergency, and all are linked by the intercommunication system installed throughout the building. The nursing stations are enclosed with heavy grill partitions for safety and to permit air circulation.

Food will be brought to each building in insulated containers from the hospital's main kitchen. The containers will fit into steam-heated serving counters in the dining rooms, and patients will be served cafeteria style, with the exception of those who are too disturbed.

Other special features of the new buildings are the visitors' lobbies, barber and beauty shops, a recreation room and O. T. and crafts rooms. Security-type windows with full detention screens are used throughout, with wire glass in the private bedrooms.

All floors are of vitreous hard clay tile laid with a close, hardened and waterproof joint. The exterior walls and partitions inside the buildings (such as corridor walls) are constructed of glazed structural tile with hardened mortar joints.

Buildings are heated by radiant heat, using forced hot water; forced ventilation is provided for rapid air circulation in all the new units.

The total cost of the four buildings is estimated at $2,948,700.00, or $4,850 per bed. The total gross area for all four is 168,000 square feet, or 276.3 square feet per patient.

W. P. Beckman, M. D.
State Director of Mental Health

Mental Hospitals

March, 1954
Volume 5 Number 3

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American Psychiatric Association

CONTENTS:

Published monthly, 10 times a year, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Institutional subscription rate $2.50 a year. Individual subscription rate for staff members of subscribing institutions, $2.50 a year. Published by the American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Avenue, N. W., Washington, D. C. Entered as Second Class mail matter, August 1st, 1952, at the Post Office, Washington, D. C., under act of March 3, 1879.

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Permanent Program Develops from "Total Push" Attempt

By W. L. PATTERSON, M.D.
Superintendent, Fergus Falls State Hospital, Minnesota

Our "Total Push" program was organized in June, 1950, as a research project, as we were not sure that it would be of sufficient benefit to justify the expense. Ten male and ten female patients were selected from among the most regressed patients in the hospital and placed in medical-surgical units. They were between the ages of thirty and fifty years with a diagnosis of some type of schizophrenia and had been hospitalized over five years.

Twenty electroconvulsive treatments were given each patient, but an early attempt to use psychotherapy was abandoned in favor of simpler activities. All techniques designed to lead patients toward increased social activity were used, and a scheduled program covered activities from the time of arising until bed-time. Personal hygiene was stressed; toilet training regimes reminiscent of infant training were used; and meals were utilized to increase sociability and, of course, to improve social manners. Recreational activities ranged from throwing bean bags to playing games of whist and softball. Occupational therapy began with the tearing of strips of cloth and worked up through skilled sewing and carpentry. Patients were kept on the program at least six months. Those who showed indications of continued improvement remained with the next group of "Total Push" patients, while those who had failed to improve were transferred to other wards.

Selection and Controls

Two entire wards were made available for the second group of patients, who were selected in somewhat the same manner as the initial group and given six months of similar treatment. All recently lobotomized patients were also assigned to the new units. A third experimental group followed with another six-month program.

Patients continuing to improve from the previous group and recently lobotomized patients remained on the units to receive "Total Push" treatment. Eighty-four patients went through the experimental part of the program. Control groups of patients getting ordinary ward treatment were used during the first two experimental periods and statistical analyses were made of all data.

Conclusions on Study

Our conclusions regarding the regressed patient study were: (a) Most regressed patients will benefit somewhat from a "Total Push" program. (Patients who have been untidy may become tidy, although they might not work; patients at a slightly higher level may work.) (b) One year after treatment, male patients tend to maintain their improvement while female patients frequently return to pre-treatment levels. This subsequent female regression may be due to a situation common to most mental hospitals —male patients are more highly prized as "workers" than female patients, because there are many more jobs that they can do. Therefore, when a male patient is transferred off the "Total Push" program and has a job assignment, he probably receives continued attention. This does not usually happen to the female patients; but in the few cases where it has occurred, it has been gratifying to note that these patients tend to retain the improvement made on the "Total Push" program. (c) Patients selected at random for the "Total Push" type of treatment tend to respond as well as patients selected because of a shorter length of hospitalization, higher pre-treatment behavioral level, or being older when first admitted. We thought we had isolated these three prognostic factors, but they did not hold up in a cross-validation. During the course of the program seven patients from the experimental groups were discharged as opposed to none from the control groups. However, only two of the discharged patients made what we consider an adequate recovery.

No scientific study was made of recently lobotomized patients during the course of our experimental program, but work in other hospitals seems to indicate that the months immediately following lobotomy can be successfully used to retrain the patient in more acceptable social behavior. Many of our recently lobotomized patients improved considerably, and quite a few were discharged. However, the results are inconclusive since we could not determine from our data how much of this improvement was due to the effects of surgical procedure and how much resulted from our "Total Push" program.

Our experimental program had a definite effect on the entire hospital. Since all but the top personnel on the "Total Push" units were changed at six to nine-month intervals, trained employees began taking some of the "Total Push" techniques they had learned to other hospital units. We do not know how directly the techniques were applied in other wards, but we have strong reason to believe that these employees are now more effective than they were before. Employee morale was increased throughout the continued treatment wards as they saw supposedly "hopeless" patients respond to "Total Push" treatment. Employees on these other units are now taking a more active interest in their patients.

Majority Show Some Improvement

Quite a number of patients who had previously required an excessive amount of nursing attention are now toileting, dressing and feeding themselves. Others are contributing work and enjoying themselves in the hospital as they were not able to prior to the "Total Push" program. There have been some notorious failures, and these patients are right back where they started. However, the fact that the majority of patients did improve while on "Total Push" has overcome any skepticism or hostility to the program.

At present our "Total Push" unit is located in a separate building with thirty-five beds for women and an

equal number for men. We usually carry somewhere between sixty and sixty-five patients on the program at a time. The program personnel includes a psychologist and a ward physician, who are supervised by the clinical director; two registered nurses; a recreational therapist; seven male psychiatric aides; five female psychiatric aides and six to ten student nurses, all available full-time, and one part-time social worker. There is a higher personnel-to-patient ratio on this program than in any other therapeutic program in our hospital with the exception of the eleven-bed insulin treatment unit. We hope eventually to put all of our continued treatment patients through this program except the geriatric patients and, possibly, long-term paranoid patients who are in contact and are well-adjusted within the hospital.

We do not consider our program unique either in techniques used or results achieved. It is well known that almost any kind of therapeutic attention given the mentally ill usually produces some change for the better. We believe that concentrating attention on a small group of patients at a time produces a few remissions, a large number of improved hospital citizens, and some dismal failures. We know that our "Total Push" treatment has resulted in positive, long-range effects far beyond the number of patients who have been touched directly by the program. It has now become a permanent part of our hospital therapeutic armentarium.

Rehabilitation

PERRY POINT PLAN APPROVED FOR VA HOSPITALS

The success of the Member-Employee plan carried on as a pilot project at the Perry Point (Md.) VA Hospital (See MENTAL HOSPITALS, September 1953) has warranted its adoption by other VA neuropsychiatric hospitals. The Veterans Administration recently notified its 38 N. P. hospitals that they may institute a similar vocational rehabilitation program if residential facilites are available for the Member-Employees.

PATIENTS TAKE PART IN COMMUNITY SERVICE PROJECT

Patients at the Eastern State Hospital in Williamsburg, Va., were enlisted in a community service project last Christmas which might well be adapted by other hospitals to many types of civic activities at any time of the year.

The Williamsburg project, sponsored by the Chamber of Commerce and Jaycees, was a "Santa Claus Telephone Service" manned by selected patients at Eastern State Hospital. A special telephone installed in the hospital library enabled Williamsburg children to "call up Santa Claus and Mrs. Santa"—as portrayed by the patients—during the pre-Christmas holidays. Nearly 2800 calls were received, sometimes at the rate of 200 a day. Dr. Granville Jones, the hospital's superintendent, reports that the patients were especially versatile in handling unusual demands, often by means of humor or diverting remarks.

In addition to being of genuine community significance, the project gave much pleasure not only to the patients who actually took part, but to the entire hospital population. The anecdotes it provided spread to the wards via the hospital "grapevine," and all patients could share in the fun. "In a very wholesome, natural way they became a part of the outside world at Christmas," Dr. Jones says. "Tensions were eased and emotions vicariously satisfied."

Dr. Jones feels that mental patients could be selected to handle other types of telephone services which would benefit the community. These might include house-to-house messages regarding defense responsibilities or safety precautions, and getting out the vote at election time. "Such services emphasize civic responsibility to those who are temporarily drawn out of the stream of normal living," he says, "and serve to keep them in touch with community life."

GROUP THERAPY PART OF PRE-PAROLE GUIDANCE

Rosewood State Training School, Owings Mills, Md., has set aside two cottages for adolescent and adult patients who show signs of being good parole material. Many of them are ready to be released as soon as the social worker can make suitable arrangements. A number, however, have emotional disturbances which mar their chances of good community adjustment. Group psychotherapy plays an important part in the rehabilitation of these patients.

Decisions on prospective parolees are made at staff meetings. If psychotherapy is indicated, the staff works out a therapy plan. One of their prime considerations is to see that each patient is assigned to the psychotherapy group in which he will work best.

The cottage program, known as the "Experimental Teaching Unit," also makes full use of recreational and other supportive therapies. The school hopes it will eventually serve as a training center for personnel.

The school has been doing a general pilot study on group psychotherapy for the past two years. One of their preliminary findings was that the best results were with patients suited for eventual parole, since they showed sufficient insight and incentive.

State Governors & Legislators Meet with Psychiatrists on Mental Health Needs

Governors Pledge Inter-State Efforts to Improve Research, Training, and Raise Appropriations

The Governors of Minnesota, Kansas, Tennessee, Indiana, Ohio, West Virginia, New Jersey, Oklahoma, Illinois and Michigan, together with state legislators, mental health officials, mental hospital superintendents, other psychiatrists, and members of other hospital disciplines from 45 States and Puerto Rico met at Detroit on February 8 and 9 to launch what Governor G. Mennen Williams of Michigan, who presided in the absence of the Chairman of the Governors' Conference, Governor Dan Thornton of Colorado, described as "the most determined attack ever made against ailments of the human mind."

Mental health has been an important subject of discussion and action at the last five annual meetings of the Governors' Conference, and the Detroit meeting was convened to focus national attention on the problems involved, to indicate what the states are doing and to provide guidance for further progress.

The main purpose of the meeting, Governor Williams declared, was to consider ways and means of preventing mental illness and of treating it effectively when it does occur.

Mental disease must be attacked at its roots. Like any other public health problem it could not be dealt with only by treating those who were already sick. It could be reduced by development of better methods of prevention, early diagnosis and effective early treatment.

"This is the task which confronts us, and in this task no state is big enough to succeed by itself," Governor Williams said. "This is one of the major areas in which the people of the United States look, not to federal authority, but to the state governments for protection against a public danger. Let us act in concert as sovereign states to solve the dread problem of mental illness."

The ten Governors pledged themselves to a ten-point program for the betterment of treatment, and prevention of mental illness. The program was signed by Governors C. Elmer Anderson, Minnesota; Edward F. Arn, Kansas; Frank G. Clement, Tennessee; George N. Craig, Indiana; Frank J. Lausche, Ohio; William C. Marland, West Virginia; Robert B. Meyner, New Jersey; Johnston Murray, Oklahoma; William G. Stratton, Illinois and G. Mennen Williams, Michigan.

The emphasis of the ten points, as of the entire meeting, was on state and interstate responsibility for preventing and alleviating mental illness so far as possible, through research, training and community psychiatric services. At the same time the Governors recognized that a major part of any state's mental health program would continue to be the care and treatment of patients in state hospitals.

Equally as serious as the shortage of money was the shortage of professionally trained mental health personnel—both psychiatrists and other professional workers.

There was urgent need for specific sums to be provided for training and research, in addition to the regular appropriations for treatment.

The Governors believe that pooling of their resources by groups of states may provide one of the most fruitful means of attacking mental illness. The importance of state governments in encouraging and supporting mental health education in the community and the provision of adequate community services was also emphasized.

EDITORIAL

One of the significant and heartening developments of recent years is the active interest in mental health programs being shown by the Governors' Conference.

The original resolution of 1949 resulted in the volume "The Mental Health Programs of the Forty-Eight States", and the facts there presented stimulated a further resolution and volume, "Training and Research in State Mental Health Programs" (1953). The volume in turn resulted in the calling of a National Governors' Conference on Mental Health, which was held in Detroit February 8 and 9, 1954.

There, for the first time in history, governors (ten of them), legislators, mental health commissioners, and other public officials and psychiatrists —nearly 300 in all—met to discuss ways and means whereby the States could better meet their obligations in the broad fields of care and treatment of the mentally ill, and training, research and prevention. Most significant of the acts of the Conference, perhaps, was the publication of a "Ten Point Program", which appears in this issue, signed by all ten of the governors in attendance.

The Conference left no doubt in the minds of those in attendance that the public conscience is clearly aroused to the significance of the problems of mental illness, the needs of the moment in personnel and facilities, and the urgent necessity of further steps looking to prevention and community care.

The A.P.A. Mental Hospital Service welcomes enthusiastically the interest and support of the governors and legislators, and looks forward to cooperating with the Council of State Governments in the furtherance of the program so auspiciously strengthened by the recent Conference.

WINFRED OVERHOLSER, M.D.
Chief Consultant,
A.P.A. Mental Hospital Service

THE GOVERNORS' TEN POINTS

And What Delegates Said Relating to Each One

1. *By far the major share of a state's mental health resources must be used for the care and treatment of patients in state hospitals for the mentally ill. Psychiatric treatment with the fullest use of* ***existing*** *knowledge can return many more people to productive and useful lives. Increased appropriations for additional qualified mental health personnel (including psychiatrists, psychologists, social workers, nurses and related personnel) and intensive treatment programs should be provided by the states at their next legislative sessions to increase the number of patients discharged from state mental hospitals.*

"It takes eternal vigilance to keep the restraints off. All groups, both public and private, must join together to make mental hospitals houses of hope, not custodial institutions to house the expendables. Not one single human being in the United States is expendable." ***Hon. Luther W. Youngdahl, Judge, U. S. District Court.***

"Legislators have problems too. They are aware of the mental health needs, but they represent constituents. You must first educate the *people*. Once they are aware of the need, they will back up the legislators. Kansas offered a good example. The public overwhelmingly supported the mill tax levy which will bring in about $2,000,000 a year for much needed construction." ***Hon. Edward F. Arn, Governor of Kansas.***

"Our first duty is to strive for a higher per diem allowance. But there are limitations. Already out of every $7 of the money in Michigan $1 goes for mental health. Thus there are two limiting factors in our State—as in others: The percentage of the budget already spent for mental health and the lack of trained people." ***Hon. G. Mennen Williams, Governor of Michigan.***

"Governors and Legislators are harassed by the conflicting demands of their constituents. But for Governors these problems persist for only two, four, eight years. For psychiatrists, the pressures pound at our ingenuity, our ideals and our heartstrings for a professional lifetime." ***Dr. Kenneth E. Appel, President, A. P. A.***

2. *Training and research in the field of mental health are essential elements of effective mental health programs. The serious accumulation of patients and costs can only be reduced by discovering new knowledge and new methods of treatment and by more adequate training and development of mental health personnel. State legislatures are urged to appropriate specific sums for training and research in addition to the regular appropriations for care and treatment.*

"Not one of the new major effective methods of psychiatric treatment has been discovered in this great country of ours!" ***Dr. Kenneth E. Appel, President, A. P. A.***

"The training of new personnel has not kept pace with the new needs; the gap between knowledge gained and its practical application is continually increasing." ***Dr. William Malamud, Chairman, Department of Psychiatry, Boston University, Mass.***

"Our training program is motivated by the conviction that the expenditure is more than repaid in numbers of patients released, although because of its scope, the total cost of our mental hygiene program remains large." ***Dr. Henry Brill, Asst. Commissioner, Department of Mental Hygiene, New York.***

3. *Ultimate reduction of the population in state mental hospitals can only be achieved by effort to* ***prevent*** *mental illness. This requires facilities for early treatment and for after-care and supervision of those on leave from state hospitals. State governments should take the initiative with both financial and professional assistance in stimulating local public and private agencies to participate actively in preventive programs.*

"There are many things that the states can do to foster prevention. They consist mostly of providing and strengthening community services which not only further prevention, but by using institutional personnel can bring these workers out of their isolation and help the people to understand that the mentally ill are not hopeless. These services represent several departments of state government —only the Governor can, so to speak, play them as a whole hand. He is so pressed with other duties that this seldom happens. It has been suggested that he be supplied with a stand-in of his own choosing to keep an eye on the whole program and see that the plays are made wisely and not bureaucratically. Such a Governors' assistant warrants serious consideration." ***Dr. George S. Stevenson, National Association for Mental Health.***

"Prevention is a comparatively new activity. Good prevention programs can stop the ever increasing populations in state hospitals and the demand for new dwellings. The best prevention program is on the community level. The states can assist the localities by providing funds to stimulate the initial project and by providing consultants to advise citizens interested in developing such programs in clinics or in educational programs." ***Hon. Bernice T. Van der Vries, Chairman, Commission on Intergovernmental Cooperation, Illinois.***

4. *At present it is estimated that less than one percent of total state mental health budgets is expended for research—$4 million out of a total expenditure of about $560 million. Based on a comprehensive survey of state mental health officials, it is recommended that the states should devote a much larger percentage of their total mental health budgets to basic and applied research in the biological and behavioral sciences and to the training of personnel in research methods.*

"The answer to few problems can be found all at once. Rather, research moves deliberately, with the investigators attacking a little corner of a problem, solving it, moving on to another part and then another part until enough of the pieces are solved to open up the possibility of a major finding. Through joint planning, areas of greatest need could be explored more systematically and many d fferent facets could be undertaken simultaneously. Mutual participation in a clearing house for research activities would be a major first step. This is the way to mutual stimulation and education, the avoidance of unnecessary duplication of effort, the saving of all too scarce research monies and

Governor G. Mennen Williams, of Michigan, shows Dr. Margaret E. Morgan, Mental Health Commissioner, Indiana, and Dr. Kenneth E. Appel, President, A.P.A., the exhibit of the State's Mental Health organization. The exhibit, which showed education and research centers, clinics and mental hospitals, was prepared in the central office of the state.

most important, the conservation of the efforts of scarce personnel. Combined research meetings and close liaison between our research workers need not jeopardize the integrity or autonomy of anyone. Research in mental health is a field too big for any of us to encompass alone." ***Dr. Harvey J. Tompkins, Director, Psychiatry and Neurology Service, Veterans Administration.***

"Recruitment and training of personnel for research purposes has been one of our most important tasks. We have tried to develop a system in which academic freedom, leisure for reflection and freedom from service duties will be combined with a stable and reasonably secure economic situation. Emphasis has been upon productive work and there are no publication requirements nor is publication forced. Research workers have been encouraged to secure academic recognition and to establish affiliations with various teaching organizations. We have found it necessary to make financial arrangements for disbursement as flexible as possible and to reduce to a minimum the need to anticipate budgetary needs too far in advance. Much flexibility has been lent by various project limited grants which make available sums of money for equipment and personnel rather rapidly. All grants, however, have been strictly subsidiary and the State support has been planned to be sufficient to maintain the necessary operation of the unit." ***Dr. Henry Brill, Assistant Commissioner, Department of Mental Hygiene, New York.***

5. *Effective training and research programs cannot be achieved without effective organization. A position of director of training and research should be established within the mental health agency in each state to assume responsibility for the coordination of mental health training and research within the state's jurisdiction. A technical advisory committee, composed of scientists and educators in the field of mental health, cooperating with scientists in universities and industry, should be established in each state to advise and assist the mental health agency and other state departments concerned with the coordination of training and research activities.*

"Research, in a measure as it increases our knowledge, also increases our awareness of new problems and multiplies the need for further study." ***Dr. William Malamud, Chairman, Department of Psychiatry, Boston University, Massachuetts.***

"In our Central Office of the Department responsibility for research has been centered in an Assistant Commissioner, who acts as the Central Office representative of the various research units, represents them in their dealings with the central agencies, acts as coordinator at the same time and furnishes a channel of information perhaps with an element of interpretation which is sometimes useful in translating the technical language of the research scientist into the no less exacting and technical language of the administrative world. The value of such liaison can be very great, especially when it is necessary to reconcile the non-routine needs of scientific groups with the routine procedures of normal business and personnel management." ***Dr. Henry Brill, Assistant Commissioner, Department of Mental Hygiene, New York.***

6. *State institutions which are not accredited for residency or as affiliate training centers for psychiatrists, clinical psychologists, social workers, nurses and other professional groups should receive support from Governors and legislatures in their endeavors to raise the level of teaching and supervision in their institutions to secure accreditation.*

"We all do some training. If we hire untrained persons we must show them how to do their job. For more complex tasks these training projects become more complicated. Because every institution has to do some training, they should be provided with adequate facilities for training at various levels. But leave the plan so flexible that local universities and other training institutions in the community can be used. Teaching is their business." ***Dr. Jack R. Ewalt, Commissioner of Mental Hygiene, Massachusetts.***

"On November 14 the Southern Governors' Conference adopted a resolution asking the Southern Regional Education Board to survey training facilities and report where additional students might be trained; to survey research under way and recommend where further research might be undertaken; to encourage states to make official surveys of training and research facilities particularly in mental institutions; to hold a Southern Regional Mental Health Conference not later than July 30th, 1954 to discuss the surveys and to draw up interstate compacts, and finally to report results and action to the 1954 Southern Governors' Conference.

"Training and research are to be the major concern of this project, and service and prevention are to be considered only as they pertain to training and research.

"Psychiatrists, clinical psychologists,

psychiatric social workers and psychiatric nurses are to be considered as mental health personnel, and research into the behavioral and biological sciences as related to mental health are to be encouraged.

"The states involved in the project are prepared themselves to answer on the problems of mental health, training and research in vital supporting and related occupational and professional groups, such as technicians, therapists, teachers, clergy, physicians, nurses, social workers and lawyers." ***John E. Ivey, Jr., Director, Southern Regional Education Board.***

7. *The states should provide stipends for graduate training in the psychiatric field, should adjust salary scales and should provide educational leaves of absence so that state mental hospitals may compete effectively for the limited personnel available to fill treatment, teaching and research positions.*

"(Mental health) is big business. But America has thrived on big business. A forty-five or sixty million dollar business would not tolerate the meager staffs and inadequate salaries that are paid in the several offices of many states to supervise and guide, wisely, progressively and efficiently the expenditure of such sums. They would pay high salaries, obtain adequate personnel to do the job all the way through the system, down and through the state hospitals themselves. They would study the savings that could be made, where the concentrations of effort and skilled personnel counted most, to increase the quality, quantity and serviceability of the product . . . Inadequate wages and salaries, poor living conditions, circumscribed, isolated environment for staffs and their families, over-work, frustration and harassment—these are the conditions in which the majority of the mental hospital staffs work. It is remarkable that many of them do such a progressive job." ***Dr. Kenneth E. Appel, President, American Psychiatric Association.***

"In view of the needs that exist today it is highly desirable that we take steps to assure a steady influx of candidates (for psychiatry and allied professions) by reaching out into the field and creating conditions which will serve as a stimulus for young people to become interested in this field through a realization of the needs as well as the opportunities it offers. We will have to undertake more active educational participation, particularly in colleges and professional schools and make students aware of the magnitude of the problem and the potentialities for public service that they will find in this work. We have to assume greater responsibility in the teaching programs in medical schools, schools of social work, nurses' training, clinical psychology, occupational therapy and others.

"One way whereby this can be accomplished is the organization of combined training faculties, as at present in Illinois, Massachusetts, Kansas and some other states. The programs in most instances have central focus in a metropolitan area with close cooperation with one or more medical schools. With this as a basis, a training program is established which utilizes the combined facilities of a number of institutions, each one of which can offer opportunities for experience in certain special aspects of the field, and when all of these are pooled, the training potentialities can be augmented both qualitatively and quantitatively. With this as a nucleus one can reach out into the periphery and organize a progressively increasing number of hospitals with an exchange of teachers and facilities." ***Dr. William Malamud, Chairman, Department of Psychiatry, Boston University, Mass.***

8. *One of the important obstacles to adequate evaluation of procedures and therapies is a lack of uniformity in statistical methods in mental hospitals and clinics throughout the country. All states should cooperate with the United States Public Health Service and the American Psychiatric Association in the adoption of uniform terminology for statistical reporting procedures in the field of mental health.*

"The Model Reporting Area for mental hospital statistics has as its objectives:

(1) The development in each State mental hospital system of a strong central statistical bureau.

(2) The development and use of standardized definitions of the various categories of mental hospital patients.

(3) The production of a standard set of basic tabulations that every State hospital system should have.

(4) The encouragement of the use of statistical methods appropriate to the analysis of data on patients followed for long periods of time.

"The statisticians in eight Model Reporting States have indicated their interest in undertaking certain studies of using uniform definitions for admissions and discharges and uniform methods of analysis. A body of data derived from such studies can add immeasurably to our knowledge of what goes on in the mental hospitals of the nation, particularly if they are accompanied by additional carefully planned studies designed to relate the effects of changes in patterns of treatment and care to the findings.

"I wish to emphasize that the Model Reporting Area is not a 'closed corporation.' We hope that those States that are now developing statistical offices and others that may be planning to organize such departments will be willing to agree to the objectives of the Model Reporting Area. States interested in joining should write to the Institute for information about procedures in applying for membership." ***Dr. Robert H. Felix, Director, National Institute of Mental Health.***

9. *Joint action by groups of states may provide one of the most fruitful means of attacking mental illness. This can be partially achieved by periodic regional mental health conferences, regional programs such as that now sponsored by the Southern Regional Education Board, and by active participation in the Interstate Clearing house now being established through the Council of State Governments by request of the Governors' Conference. The clearinghouse, in cooperation with existing public and private agencies, will provide a medium for exchange of pertinent information among the states, will assist the states in organizing more effective mental health programs, and will help in developing interstate agreements so that groups of states can utilize to the fullest extent existing training and research facilities.*

"We are organizing our staff and developing working arrangements with other organizations and agencies

to provide consultative service relative to the organization and operation of governmental services in the mental health field. We propose further to make arrangements with the mental health organizations in the states and with the professional organizations and agencies concerned to provide technical and professional service on a consultative basis to any state interested in developing, expanding and perfecting its mental health practices. For those purposes agreements can be developed by the various states and the technical and professional organizations for the use of some of their personnel from time to time on a short term basis." ***Frank Bane, Executive Director, Council of State Governments.***

"The American Psychiatric Association stands ready to render greater service to the various states by providing consulting teams who would visit in the state at the request of the Governor to study their problems and recommend to him the type of state organization of mental health that might better serve his needs as well as give advice on some methods of operation. Many times an incoming Governor in a state, with the very best intentions . . . may take unwise steps because of not having sufficiently broad counsel and advice on the most progressive or far reaching methods of furthering the mental health program of his state." ***Dr. Kenneth E. Appel, President, American Psychiatric Association.***

"The trend toward interstate compacts, agreements, and operating practices has been one of the very gratifying developments of the last quarter century or more. A notable field in which this could be developed further is that of training and research. A small and sparsely settled state can hardly be expected to set up all of the facilities which a large and populous one can. Furthermore, it is quite likely that some small state might have some practices and facilities which would be uniquely worthy of emulation in a neighboring large state. It is for this reason that the Governors' Conference only last year directed the Council to organize effective programs of interstate cooperation for the purpose of promoting mental health. It proposes, therefore, to establish immediately an interstate clearinghouse for the dissemination of information to all the states in the realms of treatment, care and prevention; to make arangements with the various states and with professional organizations and agencies to provide technical and professional service on a consultation basis to any state interested in developing its mental health practices and procedures. It may be pointed out in this connection that there are already existing agencies, notably the American Psychiatric Association, which, through its Central Inspection Board and its Mental Hospital Service, has devoted much thought, energy, and money toward the problems of gathering and disseminating information. The services of these organizations will be available to such a clearinghouse and it is certainly to be hoped that the existence of these private organizations may be expanded rather than hampered by the work of the proposed organization. Here, as in the field of research, cooperation rather than competition should be the watchword." ***Dr. Winfred Overholser, Superintendent, St. Elizabeths Hospital, Washington, D. C.***

"Regarding VA and State hospitals, cooperation must be more than an appealing word. Since mental hospitals and clinics are for the most part public agencies, there is unique opportunity here for cooperation. It is, of course, necessary that each governmental unit retain its integrity, its autonomy, and its right to shape itself to meet its particular mission. When we speak of cooperation here we do not, therefore, mean any organic integration. We do mean a pooling of professional resources, if this is advantageous to both, and a willingness on the part of each to perform such professional activities on behalf of the other as it can reasonably be asked to do." ***Dr. Harvey J. Tompkins, Director, Psychiatry & Neurology Service, Veterans Administration.***

10. *State and community mental health organizations should play important roles in educating the public to the problems of mental health and to the methods of improving psychiatric services. The states should encourage and support mental health education in the schools, good relationships between hospitals and their surrounding communities, and the provision of adequate community psychiatric services. These may, in the long run, be most important in determining the mental health of the nation.*

"Mental illness is everybody's interest—but it is always a secondary one. The mayors are interested in city needs; the rural authorities in road building; the teachers in education. The mentally ill have no adequate voice. Legislators and politicians must make up their minds whether they will buy political security by giving funds to those who have votes or risk it by taking care of those who cannot speak for themselves. This takes courage, not only on the part of the politicians but on the part of everyone. We must eliminate the state line as a barrier against the recovery of mental patients. Four groups must cooperate—the medical researchers, the medical educators, the mental health service and the state governments. We must all work together to come up with a coordinated program. Unless we have a program that we can all agree upon, we have nothing. At this meeting we must coordinate our concrete proposals and mobilize a mental alliance against mental illness." ***Governor Frank G. Clement, Tennessee.***

"Mental health does require the initiative and encouraging efforts of government service. . . . The combination of enterprise, public and private, state and local, is the only sure way to advance. I can assure you it immediately requires only one thing of you—to start." ***Senator James J. McBride, California.***

The Summing Up

A Reporter's Abstract from a Talk by Karl Menninger, M.D.

During the last two days we have heard Governors and legislators from 45 states and Puerto Rico saying that mental health, its prevention and its cure, is the intimate concern of all the people. We have heard them pledge themselves and the people of their states to take active measures to improve research and training, to give adequate appropriations and to bring the community in to support preventive measures. We psychiatrists have been saying these things for 20 years. And now the Governors are telling us. "Forgive us our happiness!"

An important instrument in educating the public to our needs is the Press. The Press has been responsible for every major wave of improvement, because they are the ones who have told the story. They know that if a story about a cat up a tree will mobilize the entire fire department in a city that the plight of thousands of fellow human beings will move people. Yet in some places the Press is persona non grata. The superintendents won't let them into the hospitals. I say our hospitals should be a daily assignment to reporters. There are plenty of good moving stories in them. And the good hearted, generous, earnest, ordinary American people, with plenty of troubles of their own, will respond. We should never underestimate the idealism of the ordinary American people.

We leaders are at fault. We haven't told the people the truth. We haven't told them that things are still bad. We haven't let them into our hospitals. We haven't asked enough of them.

Now this word "economy." It is a good word, and mental hospital care and treatment should be as economical as possible. But we are dishonest or ignorant if we lead people to think that we can cut below the minimum A.P.A. standards and really save money. Cutting cost in mental hospitals is not a matter of clever management. These standards were developed carefully and represent the absolute minimum at which the cleverest administration can possibly operate a barely acceptable program.

Now the Governors have discovered what we have known for many years—that things are bad—that we must all work together—doctors, government and people. But there must be no compromise—no compromise with truth, no compromise with science, no compromise with the rights of our fellow men.

KARL MENNINGER, M.D.

Industrial Therapy

PLACEMENT COMMITTEE PLANS WORK ASSIGNMENTS

The assignment of patients to work details at the Kentucky State Hospital at Danville is handled by a five-member committee which meets once a week. The Chaplain serves as chairman. He keeps a card index of all placements, and when possible, includes a record of job compatability, achievement, and potentialities. The food supervisor, the laundry superintendent and the farm manager are on the committee. The head supervisor is a valuable member also; she occasionally is able to recommend a patient from the back wards who was overlooked. She also arranges inter-ward transfer of patients, when feasible, so that they can be more conveniently picked up for and returned from work details.

Most of the work placements come from the continuous treatment wards. A few, however, are also drawn from the newer admissions who are under active therapy. These are usually chosen from the "Club House Group." The Club House is a social center where, under skilled supervision, active treatment patients can spend their leisure hours, watching television, playing indoor games, and cook their own noon meal. If the Club House staff feels a patient is not profiting from this environment, he is assigned to a work detail.

Volunteers

VOLUNTEERS ARRANGE TROUT FISHING FACILITIES

Through the efforts of Gray Ladies and Gray Men, patients at the Utah State Hospital in Provo enjoy trout fishing throughout the summer months. An irrigation ditch which passes through the hospital grounds was screened at both ends of a 300-yard range. The Red Cross volunteers made arrangements with the State Fish and Game Commission to stock the ditch with legal size mountain trout. Several hundred pounds of the trout, ranging from 7 to 14 inches, are put in each summer.

An annual event enjoyed by all patients who can participate with supervision is "Huck Finn Day," on the opening day of fishing season. Poles and lines are provided by the Gray Ladies. As the fish are caught they are fried on open fires, camp style, and eaten on the spot.

Patients who have ground privileges can fish there at any time during the rest of the season. Many other patients are taken there when supervision can be arranged.

"The results of the project have been very satisfactory," says Dr. Owen P. Heninger, Superintendent of the hospital, "A great deal of credit should be given to the initiative and efforts of the Gray Ladies and Gray Men to provide this activity."

STATE VOLUNTEER PROGRAM EXPANDED IN MINNESOTA

The use of volunteers in state institutions has taken a forward step in Minnesota during the past year with organized integration of such services into the State's mental health program. Volunteer services were made an official part of the Minnesota program in September 1952 when Director of Public Institutions Jarle Leirfallom appointed Mrs. Miriam Karlins as State Volunteer Coordinator. Each of the state institutions has been authorized to obtain a Volunteer Coordinator who will serve with state civil service status.

Some progress has already been made in meeting needs within the institutions. Guides regarding the use of volunteers are being established for hospital use, orientation courses set up and job qualification sheets and questionnaires used for selecting volunteers. Service record cards are in use, and a system of recruitment programs and annual awards has been developed to assure a steady flow of volunteers and to afford proper recognition for their services. Previously limited to the recreational type of activity, volunteers are now being recruited and oriented for use in such areas as nursing, social service, chaplaincy, and the library, as well as in the occupational and recreational therapy departments.

The hospitals realize that volunteers recruited on the basis of established needs and used wisely according to their potential can do much to supplement the services of the professional staff. (9-9)

COMMENTARY

A booklet to guide parents of retarded children in methods of home training has been published by the National Association for Retarded Children. The 51-page manual, entitled "The Three R's for the Retarded," was written by Mrs. Dorothy H. Moss, the mother of a retarded child, and Miss Naomi H. Chamberlain, a speech therapist and educator of retarded children. The booklet is available at 50 cents a copy from the Association, P. O. Box 85, Wall Street Station, New York, N. Y.

A comprehensive directory of outpatient alcoholism clinics has been published by the National Committee on Alcoholism, 2 East 103rd Street, New York 29, N. Y. The directory is sold for 25 cents a copy.

The January issue of the American Journal of Psychiatry contains a "Review of Psychiatric Progress 1953," consisting of brief articles on developments during the past year in clinical and administrative psychiatry and allied fields. The authors include specialists in psychology, psychiatric nursing, social work and other disciplines, as well as psychiatrists.

"Problems in Feeding the Tuberculous Patient" are discussed by Dr. Horace R. Getz in the January *Journal of the American Dietetic Association.* The article covers both nutritive needs and sanitation measures.

A pictorial booklet for family and friends of patients entering the Downey (Ill.) VA Hospital was published by the hospital under the sponsorship of the Chicago B'nai B'rith Council. "The Hospital and the Community" shows photographically the progress of a typical veteran patient from the time of his admission until discharge.

A special diet formula for patients who have difficulty in chewing and swallowing even the softest of solid foods is described in the January issue of the *American Journal of Mental Deficiency.* The formula, which is a dry mixture to which water is added, was developed by the Nutrition Division of the N. Y. State Department of Mental Hygiene. The formula is now manufactured commercially in a variety of flavors.

Mr. Donald H. Goff, Supervisor of Education and Program of the N. J. Department of Institutions and Agencies, describes the Department's plans for its institutional chaplaincy program in the December issue of the Department's publication, the *Welfare Reporter.* One recommendation he mentions is that there be a full-time chaplain for every 1,000 institutionalized persons.

LAST CALL FOR ACHIEVEMENT AWARDS

The final deadline for the 1954 M.H.S. Achievement Awards is March 31. If your institution plans to enter this year's competition, the four copies of the entry must reach us by the end of this month. Projects which were submitted in previous Achievement Award competitions may, if they have not already received an Award, be re-entered for consideration in this year's competition.

ARCHITECTURAL STUDY

Report on Psychiatrist-Architect Teams and New Construction

By JOHN L. SMALLDON, M.D.
Director Architectural Study Project

In response to our initial request for aid in surveying modern psychiatric installations throughout the nation, 51 architects, who are members of the American Institute of Architects, have volunteered their assistance. They are at present being teamed with psychiatrists from a list of 14 volunteers. This list is increasing daily.

The building types which these investigators have volunteered to survey number about 17, since some people have agreed to study more than one type of building. This figure includes the following building types: children's units; outpatient clinic buildings; convalescent cottages; day hospitals; buildings for disturbed patients; psychiatric units in general hospitals; geriatric services; kitchen and other service buildings; laundry buildings; maximum security buildings; medical-surgical buildings; nursery, school and other buildings for mental defectives; occupational-recreational therapy buildings; personnel residences; power houses; receiving and intensive treatment buildings and tuberculosis hospitals.

As our survey is planned, the medical member of the team will discuss the activities underway within the building, the philosophy of treatment and the psychopathology of the patients under treatment therein, while the architect will describe and discuss the architectural requirements of the physical facilities accommodating such activities. In this manner we hope to receive programming and planning data of value to those interested in developing mental hospital activities and buildings.

The questionnaires or check-lists, which will assist the teams in the compilation of analytical material, are currently being prepared by our project staff and will include many suggestions made by our consultants. The staff will attempt to reconcile the need for specific questions on various facilities—"Good?; Satisfactory?; Poor?; and Why?"—and the advisability of leaving the survey teams free to comment, particularly on the questions pertaining to philosophy or technique of treatment, without being restricted too much by questions.

Some relatively new and well-planned buildings in the eastern area have recently been brought to the attention of this office. Improved treatment programs are made possible by the more functional nature of the buildings and they are paying marked dividends in increased recovery rates, in shortened hospitalization, in less disturbed behavior on the part of patients, in lessened problems for the personnel and in improved public relations for the hospitals. Members of our project staff have visited the majority of the buildings which follow, and plan to observe the remainder in the near future.

Receiving-Intensive Treatment Buildings
Philadelphia State Hospital, Philadelphia, Pa.; Spring Grove State Hospital, Catonsville, Md.; Western State Hospital, Staunton, Va.; Southwestern State Hospital, Marion, Va.

Medical-Surgical Buildings
Springfield State Hospital, Sykesville, Md.; Norristown State Hospital, Pa.

Buildings for Disturbed Patients
Philadelphia State Hospital, Pa.; Springfield State Hospital, Sykesville, Md.; Eastern State Hospital, Williamsburg, Va.

Buildings for Convalescent Patients
Springfield State Hospital, Sykesville, Md.; Spring Grove State Hospital, Catonsville, Md.; Western State Hospital, Staunton, Va.

Geriatric Buildings
Norristown State Hospital, Pa.

Tuberculosis Buildings
Philadelphia State Hospital, Pa.

Working Patients Buildings
Norristown State Hospital, Pa.

Medical Office-Clinic Buildings
Norristown State Hospital, Pa.

Maximum Security Buildings
Central State Hospital, Petersburg, Va.

Nursery Buildings and School Buildings for Mental Defectives
Lynchburg State Colony, Va.

Occupational-Recreational Therapy Buildings
Southwestern State Hospital, Marion, Va.; Norwich State Hospital, Conn.; Silver Hill, New Canaan, Conn.; Manteno State Hospital, Ill.; Norristown State Hospital, Pa. (Canteen-Library-Post Office Building.)

Personnel Buildings
Central State Hospital, Petersburg, Va.; Lynchburg State Colony, Va.; Eastern State Hospital, Williamsburg, Va.; Norristown State Hospital, Pa. (Nurses Home); New Hampshire State Hospital, Concord, N. H. (Nurses Home.)

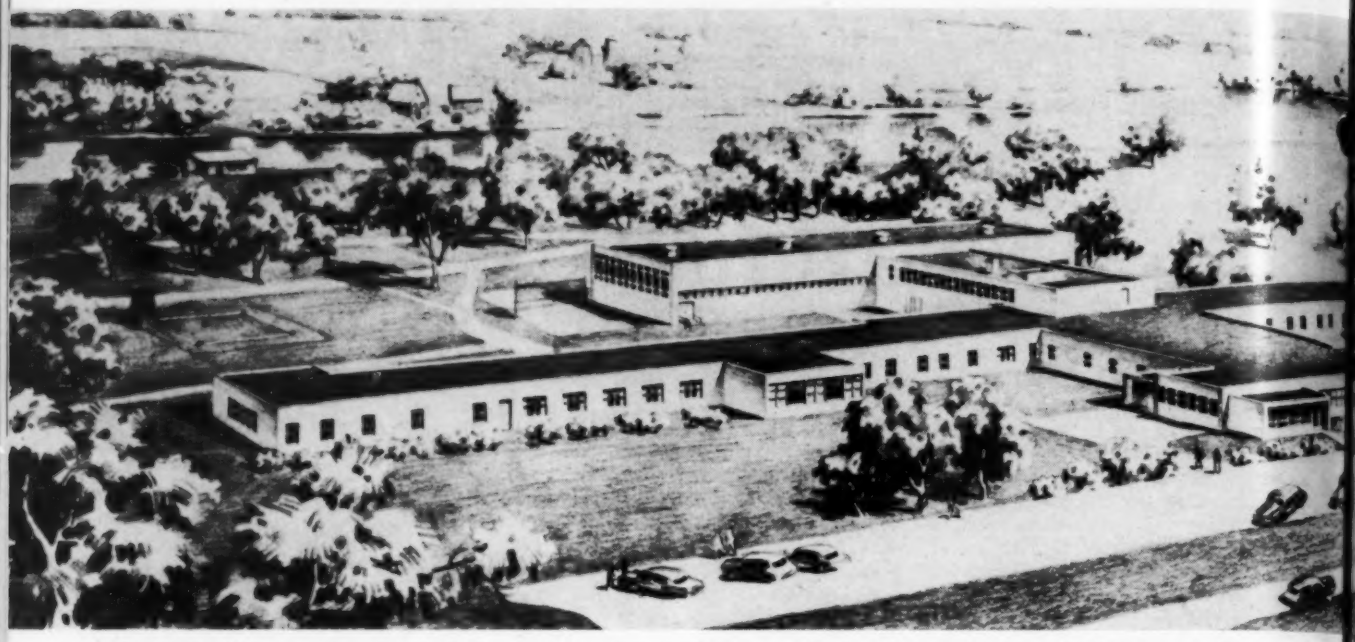
Laundry Buildings
Central State Hospital, Petersburg, Va.; Southwestern State Hospital, Marion, Va.

Power Houses
Central State Hospital, Petersburg, Va.

Central Kitchens
Philadelphia State Hospital, Pa.; Western State Hospital, Staunton, Va.

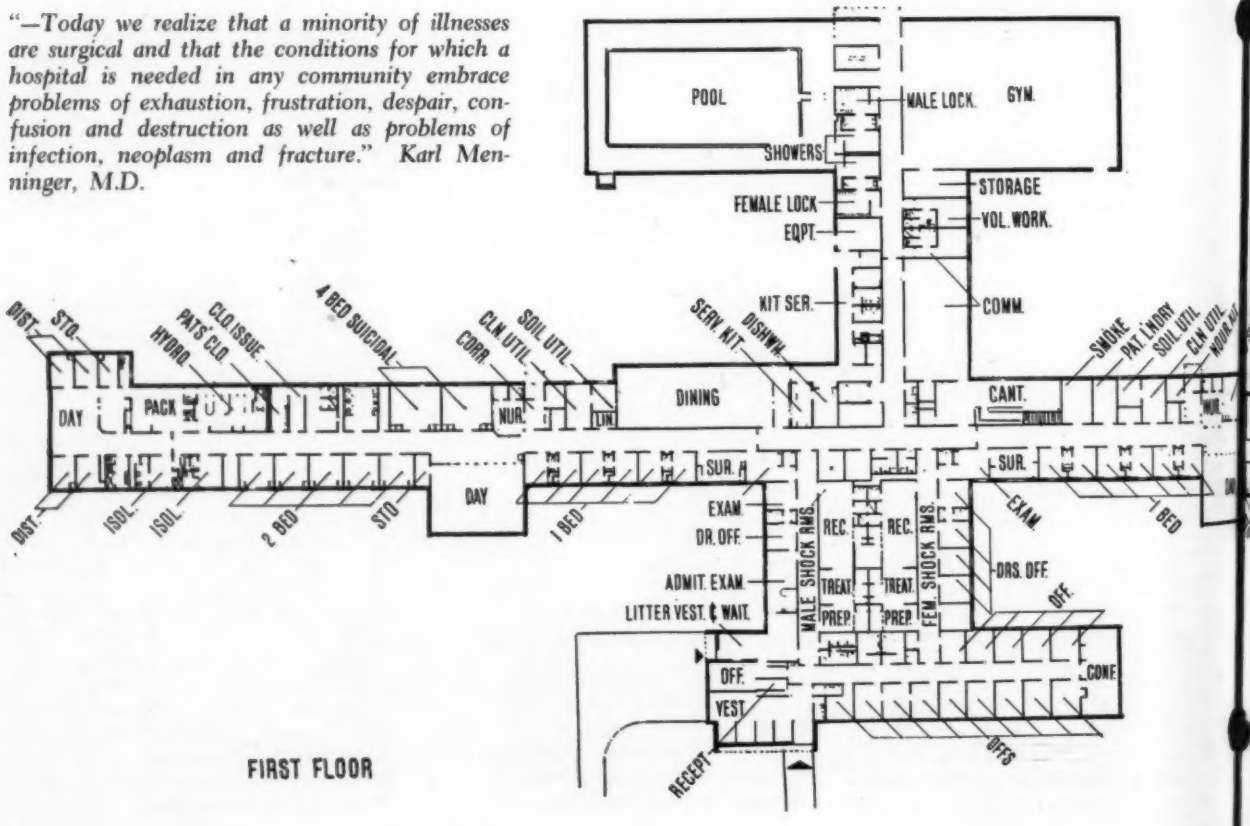
Plans are underway for a complete modern, new hospital at Miami, Florida. In the April issue of MENTAL HOSPITALS Dr. W. D. Rogers, Superintendent of the Florida State Hospital at Chattahoochee will describe how this new installation will fit into the general state mental health needs, and Mr. W. A. Gilroy of Gamble, Pownall, Gilroy-Edwin T. Reeder Associates, the project architect, will describe the plans for the first section of the hospital. This will contain about 500 beds for admission and intensive treatment, medical and surgical and geriatic patients. Copies of the plans will be presented with the article.

Other new hospitals are being constructed at Northville, Michigan; New Brunswick, Canada; Galesburg, Illinois; Williamsburg, Virginia; Westville, Indiana; Porterville, California; Wards Island, New York City, and Delaware County, Pennsylvania (in the planning stage).



(Above) Bird's eye perspective of the receiving unit. Opening off the drive are the administrative offices and some of the treatment rooms. The long arm contains the bed rooms for patients (60 beds), treatment rooms and, in the projecting bays, the day rooms; the men occupy one half of the arm, women the other. In the rear are the gymnasium and swimming pool. ▼ Below: Floor Plan of Ground Floor

"—Today we realize that a minority of illnesses are surgical and that the conditions for which a hospital is needed in any community embrace problems of exhaustion, frustration, despair, confusion and destruction as well as problems of infection, neoplasm and fracture." Karl Menninger, M.D.



FIRST FLOOR

A MODERN RECEIVING AND INTENSIVE TREATMENT FACILITY

Receiving Building, Anoka State Hospital, Minnesota

MAGNEY, TUSLER AND SETTER, ARCHITECTS

Out-door recreation areas for inpatients are to the rear of the building, away from public areas.

In designing this modern intensive treatment facility, the architects planned in terms of activities for patients and staff rather than in terms of beds. While they have provided an acceptable environment for patients, they also recognized the need of providing efficient work areas for the staff. To accomplish both of these requirements for modern treatment programs they have separated the medical treatment areas from the patient living areas of the nursing units, so that medical treatment programs may be conducted without interruption of the programs of occupation, recreation or relaxation so essential in any complete program of treatment.

Recognizing the fact that mental patients are ambulant and in need of exercise areas, outdoor as well as indoor, the architects planned a one-story building. No other building type can so adequately fulfill the requirements for activities for mental patients—the provision of outdoor areas for relaxation or recreation adjacent to living room areas to allow freedom of movement for the over-active.

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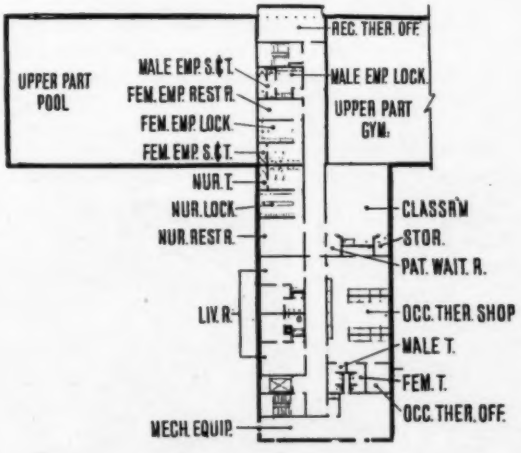
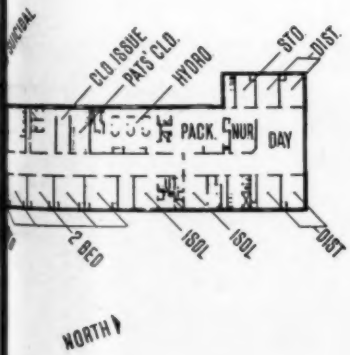
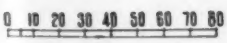


SECOND FLOOR





One wing of the building has an upper floor. It is over that portion which connects the inpatient nursing units to the hydrotherapy pool and exercise gymnasium. The upper floor contains occupational and recreational therapy facilities, a class room and various staff facilities.

This visiting area allows patients and relatives some privacy in the comfortably furnished cubicles to right, while affording supervision from the nursing station to left of the picture.

Organization

The main elements of this new receiving and intensive treatment facility are: the administrative and outpatient facilities located at the front of the building; the treatment facilities, between outpatient areas and inpatient areas, and for use by both groups without conflicting lines of traffic; the inpatient living areas, consisting of two nursing units of thirty beds each for men and for women patients; dietary facilities located conveniently for access from both nursing units; and recreational and occupational therapy facilities consisting of a canteen, occupational shops and exercise gymnasium located to the rear of the nursing units and away from public areas.

Swimming Pool Serves Dual Purposes

Hydrotherapy facilities, consisting of continuous flow tubs and pack tables, are located in each nursing unit near the disturbed patients' bedrooms. Disturbed patients will require greatest use of this therapy, and, in order that the effort of the treatment will not be lost in the travel from treatment, it is located close to the patients' rooms. A swimming pool, for use as hydrotherapy and for exercise and recreation is also included to the rear of the building.

The main entrance lobby is well lighted, attractive and inviting. It has pleasant alcoves for the private visiting of patients and relatives under observation from the information counter and the main office. This office is also conveniently located with respect to the emergency entrance and to the corridor to the outpatient department. The emergency admitting suite has access to a bedroom, bathroom and medical examination room.

Outpatient and Day Care Patients

The outpatient department has ample offices for use by psychiatrists, psychologists and psychiatric social workers and is scaled to the anticipated load for new patients' service and follow-up care.

Day care patients may use, in addition to the shock treatment facilities between outpatient and inpatient areas, the dining, recreational and occupational therapy facilities of the hospital without passing through inpatient areas.

Nursing Units Similar

The nursing units are identical in arrangement except that the women's unit has a small laundry room. Each unit has six single rooms, having connecting baths, for use by convalescing patients and these are located near the entrance to the unit. These patients have easy access to the community room, canteen, occupational therapy facilities, gymnasium, hydrotherapy pool and outdoor areas.

Five two-bed rooms for quiet cooperative patients are located beyond the day room. Medical opinions vary in regard to the use of the two-bed rooms for psychiatric patients; many doctors maintain that, in general, two-bed rooms are unsatisfactory in a psychiatric service excepting for convalescent patients' service where they may be indicated in the therapy program.

Disturbed Patients' Rooms

Disturbed patients' rooms and day rooms are located at the end of the nursing units and away from the other patient areas. It is desirable that these patients have immediate access from their living room to outdoor exercise areas. These areas must provide security, however.

A small office for use by nurses and

The bright, cheerful atmosphere, the modern, easily cleaned equipment and the show case of small "treats" which patients may purchase all help to make this patients' canteen a pleasant place to gather.

A modern, fully equipped exercise gymnasium has long been recognized as being particularly effective in the treatment of overactive patients. This gymnasium, similar to any college installation, is the gymnasium at The Menninger Foundation. The Anoka hall is similar.

hydrotherapists provides good observation to the disturbed patients' living room and the special treatment, or single, bedrooms.

A hydrotherapy suite consisting of continuous flow tubs and pack facilities is easily accessible to depressed or other patients, as well as the disturbed patients, without contact being made between patients of different behavior characteristics.

The nurses' station for each unit is located approximately in the middle of the unit and at the end of the convalescent patient area. With doors across the corridor at this point and at the entrance to the disturbed patients' area, it is possible to operate the nursing units with approximately one-sixth, one-third or all the rooms as open or as locked areas depending on the requirements of the patients under treatment. The nurses' station has good observation of the corridors, the living room, one four-bed room where depressed or suicidal patients may be under close, unobtrusive observation, and of the corridor to outdoor recreation areas.

Utility rooms, linen closet, storage closet and all facilities for nursing care are conveniently located near the nurses' station.

The dining room, canteen, community room and occupational therapy shops, where men and women patients may mix together, are attractively designed. With these facilities, together with the facilities on the nursing units, patients have available, and within reach at all times, a variety of activities for day and evening programs.

To quote Dr. Alexander Reid Martin, "All human beings, and particularly those with emotional or mental illness, need to achieve something in the way of balanced activities."

"Doctors have long urged the development of work-play, exercise-rest in the regular day's living program," says Dr. Austen Riggs.

In the past, too many mental hospital buildings have been designed to provide only custodial care in which, because of a lack of sufficient treatment facilities, patients were rigidly repressed. In this new intensive treatment building, the planners have recognized that, as Drs. McFarland, Patterson and Lee were saying in 1869, the essential elements of life for the mental patient are the same as for normal persons, and that treatment, in the majority of cases, consists of an effort to increase vitality and elevate the general tone of the patient's physical and mental life and encourage his self-respect.

In this instance, the architects have analyzed the needs of the patients for work, treatment, and relaxation, and the needs of the staff for facilities removed from, but conveniently adjacent to, patient facilities. The whole of this modern, intensive treatment facility has been conceived and carried out in terms of "total therapeutic environment."

This swimming pool at the new Veterans Administration Hospital at Brockton, Mass. is used both for hydrotherapy and for exercise and recreation, like the Anoka pool. Another hospital with such a pool says "The pool has resulted in the elimination of mechanical restraints; near abolishment of wet sheet packs and continuous tubs, abolishment of observation dormitories and almost complete elimination of seclusion rooms; a quieter ward atmosphere and a saving in personnel."

The Outpatient Department of the Intensive Treatment and Receiving Service

By ALSTON G. GUTTERSEN

Architect to the A.P.A.-M.H.S. Architectural Study

(This material, partially reprinted from the Architectural Record, is the conclusion of the material on the Elements of the Intensive Treatment and Receiving Service.)

Out-patient services must be provided within the mental hospital system if it is to meet fully its community responsibilities. A large percentage of admissions to mental hospitals are readmissions. Mental health authorities agree that this readmission rate could be reduced if proper follow-up care could be provided.

In addition to providing follow-up care, it is desirable to provide care for new patients, in the early stages of their illness, when treatment will be most effective in forestalling long and costly hospitalization. The A.P.A. Standards Committee says: "Of the patients in mental hospitals, one quarter have been hospitalized for sixteen years, one-half for eight years, and three-fourths for more than two-and-one-half years."

"The all-purpose clinic will provide: pre-hospitalization services, examination and treatment of non-hospital cases, adult and child; supervision and treatment of provisional discharged or convalescent post-hospitalized cases; supervision and care of custody cases; supervision of boarded out patients; consultation for community agencies; and provide an educational program.

"During 1950 there were more than 1,200 clinics in operation in the United States, and these clinics, three-fourths of which were entirely or partly devoted to children, saw at least 150,000 patients," according to Public Health Reports, November 1951.

Service Needs Early Planning

Out-patient mental health services may be in separate mental health clinics; in public health centers; in out-patient departments of general and psychiatric hospitals and in the receiving and intensive treatment buildings of state mental hospitals. The A.P.A. Standards say that clinics should be located preferably in connection with such institutions as general hospitals or health centers. Where they are in connection with receiving and intensive treatment facilities, the service can be enlarged to include a day-care program.

In planning receiving and intensive treatment services for the state mental hospital which is in or near an urban area, it is desirable to plan for this important function, or at least make provision for its future addition if it cannot be included in the original program of construction. Otherwise, when it is developed, it may be forced into an undesirable location, away from diagnostic and administrative facilities, with complicated and costly cross lines of traffic between in-patient and out-patient services.

Size Determined by Patient Load

In determining the size of the out-patient department, the number of interview offices required will be determined by the patient load and/or the number of psychiatric teams which will be used in this service. According to prescribed standards, each team would be composed of a psychiatrist, one psychologist (who might also serve on another team), two or three psychiatric social workers, one nurse and two secretaries. Each team can be scheduled for twenty patient hours per week. A recent preliminary survey by the N.I.M.H. of 300 clinics disclosed that the average patient interview is three-quarters of an hour; the average number of visits to any or all of the team, exclusive of nurse and secretaries, is six.

The out-patient department of a complete hospital service is usually on the ground floor near the administrative area, convenient to diagnostic and treatment facilities and removed from in-patient areas. In health centers it will be located with other patient areas, except that in large health centers, separate areas with separate waiting rooms may be desirable. The usual arrangement will require: a receptionist's counter; facilities for records, appointments and cashier; a waiting room; admitting room; medical examination rooms; men and womens' toilet rooms; interview offices for use by psychiatrists, psychologists and psychiatric social workers; staff lounge and locker room; storage closet; and janitor's closet. A library and conference room for general staff review of patient's records, and for interview of family groups or for group therapy is desirable. Clerical office space will be required, though in large clinics or in complete hospitals this personnel may be drawn from the central stenographic pool in the administration department. If a child guidance clinic is to be included, additional waiting rooms, play areas, both in-door and out-door, and facilities for one way observation into both a large play room and a small interview room or playroom are required.

Pleasant Atmosphere Important

The waiting room, near the information counter, should be well lighted and ventilated, ample in size and attractively furnished to promote the psychological aspects so necessary to the treatment and care of any patient. If the mental health clinic is in a small general out-patient service a separate waiting room is not required; in the large service a separate waiting room with separate entrance is desired. Furnishings should be comfortable and pleasant. Display boards and racks for health education material, murals, paintings, etc., which create an atmosphere of friendliness, are desirable.

The public toilets, lavatories and telephones should be convenient to the waiting area.

The information, records, appointments and cashier facilities may be combined in the mental health clinic. In health centers and hospitals, central record and cashier facilities would be used.

The medical examination room for the small general hospital out-patient service, mental health clinic or the receiving building of a state mental hospital may be placed with the other diagnostic and treatment services. In the large service a separate facility should be required. Requirements for this room are standard and will be similar to those outlined by the Public Health Service for the general hospital.

Arrangement of Admitting Rooms

Patients are generally referred first to the admitting room for consultation. It is desirable to have a waiting area near this room. The admitting room in the out-patient service of a receiving and intensive treatment service may be the same admitting room as is used for in-patients. In all other services a separate room will be required. It is especially important that an atmosphere of friendliness and welcome be created in the admitting room. The mental patient is an overdependent individual whose reactions are determined by the attitudes which are expressed toward him. The surroundings, particularly during the first interview, may do much toward obtaining the cooperation of the patient with the psychiatrist. An inviting, relaxing atmosphere is desirable. The room should be large enough for several people as the patient may be accompanied by

friends or relatives. There should be a desk, easy chair, and bookcase for the psychiatrist and two or three easy chairs for patient and relatives.

Interview offices for use by psychiatrists, psychologists and psychiatric social workers should be similar to the admitting room except that they may be smaller. In these offices complete privacy of interview or examination must be maintained during psychiatric or other interview. A small desk for use by the psychiatrist during interview is required. The patient will also be seated at the desk in order that a continued close conversational contact may be obtained. It is desirable that these offices be small, friendly and quiet in atmosphere. They should be sound-proof for privacy during interview. Offices for psychologists should have closets for equipment required for patient examination.

Play Rooms for Children

Play rooms for children's out-patient services should be furnished for both large group activities and for children at play alone. The large group room and at least one small room should have adjacent rooms for one-way observation for both sight and sound. For children at play alone a standard interview room may be used. For the large group a special room should be furnished, and this should have direct access to an out-door play area. Movable chairs and tables and ample closet space for play equipment should be provided.

The conference room may include a small library in the small hospital. In the large hospital, and when a training program is included, a separate library is necessary. In the small hospital it is desirable to have this combined facility near the medical record room in order to provide control of library books, and space for staff to consult records without removing them from the control of the record room. The room should have adequate shelving for unbound periodicals and space for a screen for viewing motion pictures.

Staff lounge and locker space should be provided for the comfort of the visiting staff. The facilities should include a sitting room, lockers, telephone, bulletin board, paging outlet, clock and lavatories. The location of the physicians' parking space will usually determine which entrance is used. It is preferable that physicians, in order to reach the lounge, should pass the information desk and the door of the medical record room. This permits efficient in and out registration and enables the record librarian to check on case records.

A.H.A. PLANNING INSTITUTE CONSIDERS MENTAL HOSPITALS

Dr. Daniel Blain, Medical Director of the A.P.A. and two staff members of the Mental Hospital Service Architectural Study Project appeared on the program of the American Hospital Association Hospital Planning Institute, held in Washington from February 15 through 19.

The object of the conference was "to promote the public welfare through the development of better hospital care for all the people," and the faculty included hospital superintendents, architects, engineers, administrators, public health physicians and other public health specialists.

The program, it was stated, was intended to serve the needs of hospital officials who expect to be involved in hospital planning. It was hoped that the architects would get a better understanding of hospital functions and hospital problems. Administrators and board members would expect to get the latest thinking of planning criteria and procedures. The emphasis would be on trends, anticipation of future needs and current thinking on hospital problems.

Planning fields discussed included the developing of a building program, planning for the care of the patient, trends in hospital planning, planning for supplies and service, for communications, for mechanical services, for safety, maintenance, design, equipment and materials and finishes.

Dr. Blain presented a paper and slides on the subject of Mental Health Program Planning, in the discussion on trends in planning for special types of care. He said that approaches to the mental health problem had gone from vague and subjective planning efforts to a more scientific, quantitative approach. The Governors' Conference and the Southern Governors' Conference had been the major spearheads toward a realistic program in mental health, especially in relation to research and training. The American Psychiatric Association had made available consultation service for complete state studies of the needs and resources in regard to the treatment and prevention of mental illness. Dr. Blain went on to outline some of the major problems and new approaches to them.

Mr. Alston G. Guttersen, the architect of the M.H.S. Architectural Study Project took part in the panel on Architectural Aspects of Mental Hospital Planning. Mr. James B. Moore, the newly appointed architectural engineer of the Study, was on the panel discussion of materials and finishes—windows, doors, hardware, etc., installed after the basic structure has been erected. Mr. Moore had been invited to take part in this panel some months ago.

Mr. Slocum Kingsbury, A.I.A., one of the Consultants to the Architectural Study Project, and a member of Faulkner, Kingsbury & Stenhouse, Architects, of Washington, D. C., led two discussions on "Planning for Communications" and "Mechanical Services."

SPECIFICATIONS SPECIALIST JOINS STUDY STAFF

Mr. James B. Moore, an architectural engineer formerly with the Buildings Materials Division of the National Production Authority, Washington, D. C., joined the staff of the M.H.S. Architectural Study Project on February 1st.

Mr. Moore will study aspects of hospital construction in relation to recommended materials and finishes for various types of buildings.

From 1946 to 1951, before joining the National Production Authority, Mr. Moore was the architectural engineer in the Division of Hospital Facilities of the Public Health Service.

STUDY PROJECT TAKES TEMPORARY OFFICES

Because of the increasing number of staff members and the rapid development of the Architectural Study Project, it has been necessary for this group to rent separate, temporary offices in the same area as the A.P.A. Washington offices.

For the time being, therefore, all mail should be addressed to Dr. Smalldon, Mr. Guttersen, Mr. Moore and Mr. Turgeon as follows:

A.P.A. Mental Hospital Architectural Study Project,
1242 20th Street, N.W.
Washington, D. C.

The telephone number is Republic 7-4736.

THE PATIENT DAY BY DAY

Dietetics

RESTAURANT OFFERS TIPS ON MAKING FISH TASTY

Because of the high cost of meat and in order to vary the patient diet, the Kentucky Department of Mental Health has long encouraged its hospitals to use fish in the diet more frequently. These meals were not too well received by the patients and employees, however, because the fish, prepared conventionally, was usually rather tasteless.

Arrangements were made with the principal supplier of fish to the State hospitals to have the hospital dietitians visit his large seafood restaurant. The dietitians were served a dinner consisting largely of low-cost seafood dishes. Afterwards they were taken through the restaurant's kitchens and were given a short course in fish preparation by the chef. He gave them a number of low-cost recipes which used home-grown products that the hospitals would have, such as tomatoes and green peppers.

The varied fish recipes now used in the hospitals have been enthusiastically received by most of the patients and employees.

FRANK M. GAINES, M.D.,
Commissioner, Kentucky Dept. of Mental Health

Recreation

HOSPITAL RECREATION CREDO STRESSES MEDICAL GUIDANCE

The following "Statement of Tenet" was issued by the Hospital Recreation Section of the American Recreation Society, and was published in the report of a study on "Basic Concepts of Hospital Recreation:"

"We Believe:

"That recreation assists the physician in his work of helping the patient get well by:

"That in keeping with the modern medical concept of treating the whole man, recreation, under medical guidance, has a vital and an important role in the treatment, care and rehabilitation of ill and disabled people.

"That recreation assists the physician in his work of helping the patient get well by:

1. Facilitating favorable adjustment of the patient to treatment and hospital environment.
2. Contributing to the development, restoration, or maintenance of sound mental, emotional and physical health.
3. Providing the physician with opportunities to observe patient response to medically approved recreation activities.

"That as hospital recreation leaders we have the responsibility of:

1. Adapting and conducting medically approved recreation programs that satisfy the needs, capabilities and interests of all patients in varying degrees of illness or disability.
2. Developing topmost professional standards and leadership qualities.
3. Continually improving and refining program content.
4. Developing factual evidence of program effectiveness through objective evaluation and scientific research.
5. Continually apprising the physician of recreation resources available to assist in the treatment, care and rehabilitation of patients."

The 26-page report of the study is available at $1.00 a copy from Miss Dorothy Taaffe, Chairman, Hospital Recreation Section, American Recreation Society, 1129 Vermont Ave., N.W., Washington, D. C.

Clothing

ARKANSAS STATE HOSPITAL INSTALLS FITTING ROOM

To take advantage of the therapeutic potential of clothing, the Arkansas State Hospital at Little Rock has revised its procedure for issuing clothing to female patients. A fitting room has been installed with mirrors and other fixtures, reports the Business Manager, Mr. Kenneth Newman.

The Chief Seamstress will make an "appointment" for the patient through the ward personnel. The patient's wishes as to color and style are complied with, within reasonable limits. The hospital purchases dress material in a wide variety of colors and prints to permit as much individuality as possible. The patient subsequently returns for fittings, and these appointments confirm the personal attention angle. The hospital feels that the new procedure will have beneficial results.

E. L. WILBUR, *Asst. Manager*
VA Hospital, N. Little Rock

M. H. S. News & Notes

Clothing Committee Preparing Guide

The first step in compiling a practical guide for hospital clothing practices has been taken by the A.P.A.-M.H.S. Committee on Clothing for Mental Patients. At a recent meeting, recommendations for a central unit for clothing distribution, certain laundry procedures, and staff ratios for such operations were considered by the Committee. The recommendations were prepared by Committee members Alexis Tarumianz, Business Manager of the Delaware State Hospital and Stanley J. Hanna, Buyer for the Rosewood (Md.) State Training School.

It is planned that, after all members of the Clothing Committee have reviewed and approved this portion of the procedure guide, it will be published for the benefit of M.H.S. subscribers.

Other aspects of hospital clothing programs which the Committee contemplates incorporating in the procedure guide include sewing room operation, the use of volunteer workers, and clothing quotas for the various types of patients. These quotas will be based on estimates which have been worked out by several states.

The Committee urgently requests any institutions or state agencies which have prepared such quotas to send a copy to the M.H.S. office. The Committee would also appreciate receiving any documents, such as portions of ward procedure manuals, which pertain to clothing practices in your institution.